DOCUMENT RESUME

ED 266 621 EC 182 039

AUTHOR Day, Pat Spencer
TITLE Methods for Enhancing Efficiency of Interdisciplinary Team Decision Making.
PUB DATE Jun 85
NOTE 16p.; Paper presented at the Convention of CAID/CEASD (St. Augustine, FL, June 23-27, 1985).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141) -- Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Decision Making; Disabilities; Elementary Secondary Education; *Hearing Impairments; *Interdisciplinary Approach; Interprofessional Relationship; *Teamwork

ABSTRACT

The paper reviews difficulties in special education interdisciplinary team decision making and relates the experiences of one team's efforts to increase intra-team communication. Among problems cited are lack of focus in discussions, unequal levels of participation, and limited abilities to produce recommendations or provide therapy in a truly integrative fashion. The team discussed, which is involved with hearing impaired students, developed methods that address two goals: (1) to increase the degree of integration and cooperation among team members; and (2) to increase the probability of the team's recommendations being implemented by school and family. The integration goal is furthered by clarifying the focus of assessment efforts, setting the agenda for assessment and staffing efforts, and modifying the questions during the agenda. To increase the probability of having recommendations implemented, four strategies are suggested, including presenting the information to all interested parties in a manner directly responsive to their expressed concerns and incorporating teacher and parent input into the assessment process as much as possible. (CL)

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METHODS FOR ENHANCING EFFICIENCY OF INTERDISCIPLINARY TEAM DECISION MAKING

Pat Spencer Day, Ph.D.
Coordinator
Assessment Center for Hearing-Impaired
Kendall Demonstration Elementary School
Gallaudet College
Washington, D. C.

Presented at
CAID Convention
St. Augustine, Florida
June, 1985

EC182039

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Teaming has become an integral part of the educational process, both in the delivery of services and the assessment process through which services are prescribed. Working in teams has become institutionalized in special education settings due to recognition of the increased knowledge that can be brought to the management of complex problems and by the advent of P. L. 94-142 and its implementing regulations. As the use of teams has evolved, three major terms have been used to describe variations in the teaming model. The most generic term refers to "multidisciplinary" teams, in which several different disciplines meet, but there is no specific emphasis on their findings and recommendations being integrated (Bailey, 1984). Numerous professionals have suggested that "interdisciplinary" functioning is a more effective use of teams. In this model, it is expected that "...interactive and symbiotic interplay of the contributions from different disciplines...." (Fordyce, 1981) will result in end products which are more comprehensive and which will more closely meet the needs of the students involved. Finally, an even more highly interactive model called "transdisciplinary" is becoming popular for some functions. This model involves "role release" and learning of knowledge and techniques from disciplines other than the one in which the specialist's training was obtained (Hutchison, 1974; Haynes, Patterson, D'Wolf, Hutchison, Lowry, Schilling, and Siepp, 1976; Lyon and Lyon, 1980). This model appears to be more appropriate for delivery of educational services or for screening-level diagnostic assessments than for highly specialized diagnostic teams.

Increasing the number of persons involved in a problem-solving team increases the potential impact on the problem. In fact, Pfieffer (1980) states that there is "less variability in both selection of diagnostic label

and educational placement made" when a team approach is employed in educational settings. Golin and Duncanis (1981) stress that interdisciplinary teaming should "result in more effective interventions." Bailey and Harbin (1980) state that diagnostic teams help prevent discriminatory evaluation practices. Despite such observations, Pfieffer (1980) and many others have identified problems which frequently occur in team functioning which result in lessening or negating the expected positive effects of teaming. Some of the problems reported are discussed below:

. Discussion in team meetings is frequently less than meaningful and lacks focus on the specific issues to be addressed (Ysseldyke, Algozzine and Mitchell, 1982; Bailey, Helsel-DeWert, Thiele, and Ware, 1983). Related to this is the fact that team meetings seem to frequently require more time than expected in order to reach closure on issues.

. Teams rarely approach the goal of equal participation, with differences in participation in team meetings related to the profession or perceived role of individuals (Yoshida, Fenton, Maxwell, and Kaufman, 1978; Gilliam and Coleman, 1981). In addition, Yoshida et al.(1978) report that individuals on the team express satisfaction with the process in direct relationship to their level of participation or self-perceived influence on the decisions made.

. Related to the unequal participation reported for various team members, Fordyce (1982) and Lowe and Herranen (1982) report that teams are frequently limited in their ability to produce recommendations or provide therapy in a truly integrative fashion. The "team" may still be providing an aggregate of unidisciplinary products and decisions.

. Decisions made by teams are frequently not implemented. This occurs in part because persons' perceived opportunity to participate in the decision-making process is a strong factor in their acceptance of the decision made

(Hoffman and Maier, 1961): those persons (teachers and aides) who are most important in the implementation process have been found to be less likely to be full participants in the team decision-making process.

The difficulties in team functioning have become so widely recognized that there are some professionals who specialize in developing methods to help dysfunctional teams improve their ability to work together in decision making (Fleming and Fleming, 1983). Others have proposed models for team decision making which attempt to remediate some of the common difficulties. These models have included emphasis on establishing agendas for action, allocating sufficient time for discussion, defining the problem by pooling information, and suggestion of alternative decisions in an initially non-judgmental format (Fenton, Yoshida, Maxwell, and Kaufman, 1978). Pfieffer (1980) focused on methods to facilitate collaboration among the professions, including a concept of shared responsibility, frequent process meetings to address the group's own needs, clarification of roles, and on-going program evaluation. Few specific guidelines have been given, however, to give practicioners activities or procedures to use to accomplish those ends and increase the degree to which their own team can come closer to meeting its potential.

The remainder of this paper will share the experience of one interdisciplinary team and outline specific procedures which it has used to increase intra-team communication and focus on the critical issues. The team to be discussed provides comprehensive assessments of children and adolescents who have a previously identified hearing impairment and whose teachers or parents have questions which the local school does not feel it can answer.

The clients of this Center, therefore, present very complex issues, requiring a significant amount of highly specialized knowledge and experience on the part of the team members. The team consists of core members in audiology, education, psychology, speech/language, social work and (when appropriate) sign communication. Medical professionals and occupational/physical therapists also examine the children who come to the center. Their information is usually transmitted to the core team via the case manager. When the client is sufficiently medically complex, however, the pediatrician or neurologist or motor specialist joins the group for the staffing, thus increasing the variety of professions directly represented. Other specialities such as art therapy, counseling, and psychiatry also join the group when needed. The team's job is complicated, therefore, not only by having complex issues to resolve but by frequently shifting team members and a large number of disciplines represented. An additional source of complication for this particular team is that the clients come from locations away from the center itself. Implementation of recommendations is a particularly problematic area since neither the child's teacher nor influential administrators or therapists who will be working with the child after the assessment can typically participate in the assessment. Given this rather complicated task, the assessment center team has developed methods to address anticipated difficulties. The two major goals of the methods to be discussed are (1) to increase the degree of integration and cooperation among team members, and (2) to increase the probability of the team's recommendations being implemented by the referring parties (school and family).

Goal 1 (integration) is approached by use of techniques to clearly establish the purposes of each assessment prior to its initiation and efforts

to de-emphasize discipline boundaries and perceived roles. Although it was decided that a transdisciplinary model would not be appropriate for this particular team, efforts were made to identify ways to emulate some of the positive aspects of the transdisciplinary model within the context of an interdisciplinary team. Toward this goal, the following procedures are followed:

.Clarifying the purpose/focus of assessment efforts. Using background information, including direct input from parents and teachers, a small group (or one person with interdisciplinary training) identifies the major concerns or issues for a particular case. Questions of particular importance to the child's parents and teachers are determined through interview or their responses to questionnaires.

.Setting the agenda for assessment and staffing efforts. A question is written for each concern identified by the review of background information and input from parents and teachers. These questions then provide the direction for the assessment, with each discipline expected to respond to each question. (For example, if a question asks about the normalcy of the child's attention span, everyone who worked with him or her will have some valid observations about the child's attending behaviors during one assessment session. Combining the information and impressions from all the disciplines will give a more comprehensive view of the child's behavior over time and under different task conditions.) Using the questions for the meeting agenda and encouraging multiple inputs to the question response serves to decrease the amount of unidisciplinary role defense and encourages more integrated interpretation of the child's performance and needs.

. Modifying the questions (and, thus, the agenda) during the assessment. After actually working with the child, some of the questions intially proposed may become irrelevant--others may arise. It is productive for the team to meet briefly, in person or by telephone, shortly after some team members have worked with the child but before all have. Those who have already seen the child can begin to propose new questions at that time and the remaining sessions can be u l to focus on information relevant to those questions. There is also a time set aside prior to beginning the decision-making staff meeting for modification of the questions. Questions are added without others making judgments about them, but questions are only deleted if all team members agree they are no longer needed.

A different set of questions is generated for each child. Tables 1 and 2 illustrate question sets generated for two different children. In practice, a core set of questions has been identified which can be used for almost all of the cases encountered. These "core" questions include:

1. In which (if any) functional areas are particular weaknesses or problems evident?

2. In which (if any) functional areas are particular strengths noted?

3. Does the child have any conditions in addition to the hearing loss which will interfere with his or her development?

4. What is appropriate educational placement for this child?

5. What related services are necessary supplements to the child's classroom programming?

6. What kind of help (if any) do the parents need to be able to help their child?

Use of the questions to serve as the agenda for testing and decision-making staff meetings has resulted in decreasing the time needed for the staffings by one-fifth to one-fourth of the previously-used time. In addition, all members of the staff responded to evaluation questionnaires indicating that they feel that the time is now being used more effectively. The following comments were given: "We are getting down to the real issues now"; "We have more time to get to the meat of the matter--the recommendations."

The second major goal is to increase the probability of having the team's recommendations followed after the family finishes the assessment and returns to their home school. This is an issue on which data are just now being gathered. The following steps are used to approach the goal of achieving implementation of recommendations:

. Presenting information/recommendations to all interested parties in a manner directly responsive to their expressed concerns. Feedback is provided to parents in an interpretive meeting held the last day of the assessment. Similar meetings are held with teachers and school personnel if they are within the metropolitan area in which the center is located; otherwise, explanation is given by telephone conversation. These meetings or conversations are again structured by using the question list as an agenda.

. Incorporating teacher and parent input into the assessment process as much as possible. This is done through use of special teacher and parent questionnaires as well as personal and telephone conversations. Teachers are invited to come to the center with the family and participate directly in the process; many have chosen to do so--in fact, two principals have traveled long distances to participate in part of the assessment activities.

Whenever possible, it would be highly advantageous to have the child's teacher be a member of the assessment team itself. Many teams have found that having the teacher chair the team meetings helps to keep the meeting focused on educationally-relevant issues and increases the teacher's feeling of participation and influence. Since the team being discussed does not have that option, it compensates to some degree by having the educational specialist function as the chair and team leader. That specialist is also responsible for communication with teachers and administrators when resulting recommendations are being explained. It is easier, it seems, for a person who has experienced classroom teaching to explain the connection between assessment recommendations and actual classroom practice.

Parents participate in the process by providing information, watching their child perform in the assessment sessions, and by actually working with the child and diagnosticians in some sessions. Family art sessions are sometimes scheduled to give the family an opportunity to think about the week's process and discoveries in an informal setting. Finally, plenty of time is set aside for the discussion with parents on the final assessment day. Parents are specifically asked during the week whether their child's performance is what they expected or whether they are seeing behaviors different from the child's typical functioning. They are sometimes asked to look for specific behaviors after they and the child return home that would confirm or disconfirm the interpretations made by the assessment team during the assessment period.

. <u>Preparing written reports appropriate for use by different professions but with the emphasis on integrated findings and consensus among the disciplines involved in the assessment.</u> Two types of reports are included in the final report packet. The first is like an executive summary which provides in two or

three pages the major findings and recommendations of the team. This summary report is structured according to the question list instead of being organized according to disciplines. Attached to this summary is a collection of the second kind of report. These reports are prepared by each discipline and provide the amount of detail required for the disciplinary specialist who will be implementing the child's program. These unidisciplinary reports are not written until after the decision-making staff meeting, however, and they reflect the general consensus of the entire team on the issues addressed.

. Presenting information that will be directly relevant to the classroom or specific therapy sessions. Assessment instruments and procedures are selected so that they include measurement of skills that are used in the classroom and the child is seen functioning on classroom-like tasks. This requires use of criterion-based measures and trial teaching sessions in addition to traditional normed tests. Then each child's report includes a list of appropriate short-term educational goals and teaching strategies tailored for the individual child and suitable for consideration as IEP goals. Similar kinds of behaviorally-stated goals are frequently included for speech, language, auditory training, sign language training, or motor areas.

Evaluation forms sent to teachers and school administrators after their students have been assessed at the center have been returned with consistently positive evaluations of the value of the assessment. The ability of the teacher in the school to talk with the education specialist directly and the inclusion of classroom-relevant goals and strategies are the aspects of the process most frequently praised. An evaluation project is currently in progress in which goals recommended for each child are listed and parents and school personnel are asked to note which of those have been implemented. Respondents are also asked

to note why some recommendations have not been implemented. These data have not yet been received, so it is not possible now to determine whether the center's efforts to encourage implementation of its recommendations have been successful.

Summary

A team functioning at an assessment center for hearing-impaired children and adolescents has developed methods to increase integration of findings and recommendations and to encourage implementation of the recommendations. Team self-evaluations indicate that the effort toward integration using a question format has been successful. The degree to which recommendations are actually implemented has not yet been determined. There is a need for teams functioning in various situations to share their experiences in trying to avoid the pitfalls in teaming which have been reported to interfere with many teams meeting their potential.

TABLE 1

QUESTIONS FOR CHILD # 1

1. In what areas is functioning below expected levels?
2. Do expressive/receptive language delays explain reading and writing problems?
3. Does he show neurologic soft signs, perceptual or perceptual-motor problems?
4. Does he show any cognitive delay?
5. Does he have emotional problems which might explain his lack of academic achievement?
6. How can we increase his self-concept and frustration tolerance?
7. What special methods can be used to increase academic skills?
8. What additional related services are needed to support programming?
9. Can we help Mom, school, LEA communicate with less defensiveness?

TABLE 2

QUESTIONS FOR CHILD # 2

1. Does she have any organic or emotional disabilities in addition to her hearing loss?

2. What is her potential for developing oral language?

3. What is her potential for developing language through other modalities? (cues, signs)--Are there indications of a generalized language disability?

4. What kinds of related services does she need provided in her educational program?

5. Do her parents have any kind of support system to help them through their decisions -- Can we help them find support?

6. How well do the parents understand the effects of her hearing loss?

7. Are there any additional stresses in the social/family environment which might be affecting the development?

8. What are appropriate short-term educational goals and activities to work toward them?

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